TREATMENT ERRORS AND IATROGENESIS ACROSS THERAPEUTIC MODALITIES IN MPD AND ALLIED DISSOCIATIVE DISORDERS

Catherine G. Fine, Ph.D.

Catherine G. Fine, Ph.D., is a psychologist in private practice in Philadelphia and Blue Bell, Pennsylvania.

For reprints write Catherine G. Fine, Ph.D., Institute of the Pennsylvania Hospital, 111 N. 49th Street, Philadelphia, Pennsylvania 19139.

ABSTRACT

David Caul's special interest in iatrogenesis became the opportunity to explore how treatment modalities may impact on the iatrogenic creation of alter personalities in patients who already have multiple personality disorder (MPD). This paper reviews basic transferences and countertransferences that can be monitored in the treatment of MPD which can, if unchecked, lead to the creation of new alters. It appears that these phenomena rather than treatment modalities per se provide the major impetus to iatrogenic increases in the complexity in MPD patients.

INTRODUCTION

Over a faculty lunch during the workshops at the 1987 Fourth International Conference on Multiple Personality/ Dissociative States, David Caul brought up the topic of iatrogenesis in connection with multiple personality disorder (MPD). He spoke of its controversial elements and some of his frustrations surrounding the entire issue. Philip Coons nodded and said: "I can give you five examples right now." Moshe Torem, still standing, but not for long, concurred as George Greaves moved towards the group. Within minutes, the rest of the room did not exist as histories, personal experiences, and observations derived from consultations started accumulating. David said, with the force of a decree: "We have to talk about this at the next meeting." Rapidly, topics were distributed. David nodded to me and said, "You look at treatment modalities." Determined to maintain composure, I managed a grin. "We'll all talk about it again before the abstracts are due," he continued. I was relieved. . . there seemed to be all the time in the world. We would discuss it in detail next spring.

David died the following March. We never did speak again. In this paper, I hope to do his intentions justice.

Problems in conducting healthy, constructive therapy sessions are not restricted to work with MPD patients, even though sometimes it may feel that way. MPD patients have the ability to make us rise to our highest potential as therapists; they also remind us how quickly we can fall to our knees. One of the more gnawing problems that I encounter, whether it be in my direct contact with MPD patients or as I supervise or consult to other therapists treating MPD patients, is the ongoing, relentless pull to renegotiate the ground rules of therapy. This tug and pull is played out between a patient whose external boundaries are as permeable as her internal ones are rigid, and a therapist who is not only trying to understand the patient, but who is also negotiating his own sometimes confusing reactions. In this paper, I will review the varieties of boundaries that MPD patients commonly attempt to cross, and discuss their countertransferential consequences in the therapist. I will then explore through some case examples taken from different treatment modalities, the errors committed by therapists responding to unexamined or poorly understood countertransference — some of which lead to the iatrogenic creation of additional alter personalities.

Some of these errors are inherent in the treatment modalities, others are errors of judgment or misunderstandings between patient and therapist, often based on rapidly cycling unmonitored transference-countertransference exchanges. Still others are errors based on the direct breach of the doctor-patient relationship wherein occur events that are inexcusable violations of any ethical code put forth by respectable professional organizations. Initially, therefore, I will review boundary violations by the patient.

BOUNDARY VIOLATIONS BY THE PATIENT

Like any other patient, the MPD patient needs to learn the boundaries of the therapeutic encounter. Often these boundaries are implied rather than stated explicitly (Langs,1974). The therapist expects the patient to know where and when they should meet to talk, what the patient should talk about, and what the therapist will or will not talk about (Langs,1974). In addition, there is often an understood code of acceptable behaviors within the session. The task of defining the milieu of the therapy is one which should be addressed at the initial contact with the patient. It may need to be frequently restated with the MPD patient who enters treatment with a diminished capacity to integrate information because: 1) her autonomous ego functions and stores of information are disseminated across personalities (Kluft,1987); 2) because the office environment becomes a

discriminative stimulus for dissociation; 3) because the different personalities tend to process information according to trance logic rather than causally; and finally 4) because they are limited by the various cognitive developmental levels at which the different personalities have fixated (Fine,1990). In addition, for the personalities who are not invested in treatment, the repeated violation of the boundaries of therapy provides an ideal opportunity to remain multiple, to not face the traumata, and to feel misunderstood, vexed, and revictimized by the therapist. Such misalliances are as much a consequence of the patient's masochism, manipulation, and desire to maintain familiar symptoms rather than face others that could be potentially worse or more painful (Fine,1986) as it might be a consequence of unresolved personal conscious or unconscious problems in the therapist. Both therapist and patient may contribute to antitherapeutic alliances, however the burden of responsibility for redressing the treatment context gone awry is on the therapist, not on the patient. Understanding how and why these boundaries are challenged helps to correct a misdirected treatment. The three primary transferences which push the MPD patient to challenge the therapeutic boundaries are: nurturant transferences, aggressive transferences, and eroticized transferences.

1) Nurturant transferences and boundary violations.

Some patients, after having found a therapist who "understands" them, lose sight of the fact that the therapist is not a friend. The therapist is a caring person, but a trained professional who has a job to do. To gratify the need for closeness, any number of boundary violations can occur. Some may be subtle — others can become quite blatant. The patient can "move into the waiting room" for hours before and after appointments. She can become friendly with the therapist's other patients. She can try to form informal social groups or organize group therapy encounters with the therapist's other MPD patients without ever bringing her plans and longings into her therapy sessions. She can comment repeatedly on therapist's clothes. She can follow the therapist around, literally spying on her. She can try to extend the therapy time by not respecting the limits of the therapy hour. She can bring up a crisis at the end of the session to extend it. She can telephone the therapist and expect to have long phone sessions regularly beyond the normative emergency or contact call. She can use up the whole tape on the therapist's answering machine knowing that the therapist will be forced to listen to the whole tape — just in case. She may inquire about the therapist's private life. She may want and ask the therapist to touch, hold, hug, reparent her. She may bring the therapist food or gifts and expect the same in return. She may suggest the therapist take her home or on vacation or, better yet, propose that the therapist never go home. The next fairly common group of transferences which lead to boundary violations are aggressive transferences.

2) Angry transferences and boundary violations

These violations are meant to be offensive. These can be violence towards the therapist or his staff or destructive acts towards objects connected with the therapy or therapist. The patient can become verbally offensive through shouting vulgarities in session, in the waiting room or worse yet, in the building's lobby. Other MPD patients may react in passive aggressive ways and withhold payment. Some MPD patients can threaten the therapist's life (which may not be a reason for terminating treatment) or threaten the life of family members of the therapist (which, for me, necessitates immediate termination of treatment and notification of the appropriate authorities). Verbal and/or physical assaults, though they are understood as encapsulated affects and acting out, can nonetheless be very destructive, potentially lethal, and overstep the boundaries of the therapeutic milieu. The last group of common transferences which challenge the therapeutic boundaries is eroticized transferences.

3) Eroticized transferences and boundary violations.

These transferences are concerned with the patient's difficulties in negotiating the experience and expression of sexual feelings towards the therapist in particular and people in general. Examples are sexualization of every comment by the therapist with attempts at bantering back and forth, sexual jokes, and provocative clothes or make-up. Touching or trying to touch the therapist in an inappropriate way are common expressions of a sexualized transference in an MPD patient.

The therapist's appropriate responses to all these transferences and boundary encroachments are therefore crucial. His satisfactory dealing with the situation will be the beginning of a corrective therapeutic experience designed in part to help the patient unlearn behaviors which lead to victimization as an adult, and to relearn less self-destructive responses. Patients, however, are not the only element in the therapeutic dyad who may overstep their roles. The next section will describe how the therapist, too, can violate the understood rules of treatment.

BOUNDARY VIOLATONS BY THE THERAPIST

The therapist may be overwhelmed or too eager; he may be numbed or overly preoccupied; he may overstep his actual knowledge and break the limits of his role. Sometimes, rather than acknowledge these to himself and make his reactions grist for the therapeutic mill . . . he may act on his feelings and be aggressive, seductive, or overly nurturing. He may do something radical, self revealing, or more intentionally erroneous (Langs,1974). He may respond to the patient's immediate symptoms/needs or the symptoms/ needs of one of the personalities, losing sight of the whole individual and the treatment goals. In the next section, I will review some of the countertransference reactions exhibited by therapists which may lead to the iatrogenic creation of similar or novel alters in a variety of treatment modalities. But preliminarily, two essential points need to be understood: l-MPD is not created through countertransferentially based boundary violations, however additional alter personalities can be thusly created in a patient who already has MPD; 2-excesses and misuses of a particular treatment

modality does not make the correct application of that modality suspect.

1) Nurturant countertransferences and iatrogenesis.

Of all the countertransferential reactions elicited when working with MPD, a nurturing one often predominates the initial phases of treatment. It is tenacious and its mishandling can undermine therapy from the start. The therapist feels sorry for the patient's plight and helplessness. He may forget that the patient is an adult, not a child, and that she is in therapy to conquer the regressions, not give in to them. The therapist may tolerate or even initiate more closeness with the patient, losing sight of the fact that other types of personalities occupy the body. The therapist's unspoken message is "I see you are weak and helpless; I am strong; I will take care of you" instead of "I will help you learn how to take care of yourself."

Depending upon the character structure of the patient, the type, nature, intensity, duration of the abuse and also idiosyncratic elements in the patient's life — this familiar double bind will be the opportunity to create one or both of two kinds of personalities iatrogenically: 1) more helpless, pathetic children, or 2) more aggressive alters who are (justly) offended by the therapist's antitherapeutic suggestions.

*Case History 1 (cognitive therapy).

A suicidal 24-year-old female nursing student came to treatment transferred from a very nurturing MPD therapist who herself had MPD and was becoming overwhelmed by the patient's reactions, with which she overidentified. Both patient's more mature personalities and previous therapist were aware of boundary problems which prompted the transfer. The personality who best connected with the initial therapist was a child personality. The new therapist, suspecting that there were many more child alters, and, that the suicidal urges came from them, decided to work in a cognitive mode to deal with the depressogenic schemata of the child alters. Part of the treatment involved behavioral components designed to have the children experience a corrective positive involvement in the outside world. The new therapist's instructions were "Go out and make friends." Within a month's time, the child personality came in, very proud of herself, handed the new therapist two full pages of names, and said : "I hope you will be proud of me; on this page I wrote down the names of all my old friends and on this other page I wrote down the name of all the new friends *I just made.*" This child personality had created 10 new child personalities to please the therapist.

This is an example of a therapist's inadvertently fostering the creation of another group of weak, depressed alter personalities using fairly traditional Cognitive-Behavioral interventions. The therapist rushed in too fast. However, acting on nurturing countertransference reactions can also lead to the iatrogenic creation of an angry alter personality as in the co-therapy model to follow.

*Case History 2 (co-therapy).

A 30-year-old female had been in supportive psychother-

apy for six years prior to the diagnosis of MPD. The original therapist, feeling both overwhelmed and fascinated by the diagnosis, requested to work with a cotherapist who had some expertise in MPD. Both therapists concurred that a more psychodynamic interpretive therapy would serve this patient well. Personal events in the original therapist's life (a pregnancy) combined with the second therapist's repeated concerns about the first therapist's overreliance on the second therapist's skills rather than taking steps to develop an appropriate familiarization with the field, contributed to the original therapist's progressive withdrawal from the treatment in general and from the second therapist in particular. The first therapist was very mothering and resumed a supportive stance; the child personalities went to her. The second therapist was more confrontative, the adolescent and adult personalities went to her. The children changed little, but the adolescents evolved; enough work was done with them that a second layer of adolescent alters, angrier and meaner, emerged. They hated men; but they also hated the fact that little had changed, that the children were still hurting. One of them created a new female alter to hold and express hateful feelings toward the female therapists and to get the patient out of treatment. This alter justly complained that although the children need love, they also need to grow up in order to stop hurting. She protested that the therapists were keeping the children from growing.

The cotherapy model is less at fault here than the misalliance between the two cotherapists. It was as if the only way the patient could express her distress and confusion at the situation and tell the therapists that she knew how crazy it was getting was to create this new alter. It is also an interesting illustration of how the original therapist's nurturance was perceived as a continued traumatization and elicited the creation of an alter to stop the therapy and therefore stop the abuse.

*Case History 3 (a Rogerian model).

A third case history involves how a Rogerian therapist following the nurturing principles of his school of thought (which is to follow the patient in an unstructured way and reflect back the patient's expressions) became overwhelmed by the manifold directions the patient straddled simultaneously. The treatment paradigm here would unwittingly parallel Kluft's (1988) description of chaotic "Nantucket Sleigh Ride therapy." The treatment became confused and eruptive until a combination of an iatrogenically created alter (who became a welcome cotherapist) and consultation reduced the incidence of crises.

The patient was a 38-year-old female with MPD who is working on a master's degree. She has been in treatment for approximately one year. The parental abuse she endured started at birth and continued well into her twenties. In addition, she had been used in child pornography during the first decade of her life. The therapist was a calm and generous pastoral counselor who is also a minister. He was working with his first MPD patient, and had a rather disorganized and undisciplined approach to treatment. He had been spending up to four or five hours a day working with the patient, whom he used to let sleep on his living room couch

when things got overwhelming for her. The patient initially presented to treatment with 25 personalities. These personalties literally took him "all over creation." An alter with a therapist function was created within the system to help the counselor and to be the official record keeper of the treatment. The therapist's own behavior encouraged this — he did not like to take notes. The therapist finally sought consultation. The consultant's primary recommendations regarded the importance of the establishment of boundaries. The therapist believed this "therapist" alter was an ISH, and that the treatment was progressing well, but the consultant believed it was created in response to the confusion in the treatment, to try to stabilize the system. In support of this latter view, the iatrogenically created part did stabilize the system by bringing information to the sessions that allowed for better crisis management; a minimal change in establishment of more stable boundaries suggested by this personality also allowed for less acting out and the discovery of yet another layer of personalities.

The Rogerian client-centered perspective, though nurturing, interacted with and was reinforced by the therapist's own difficulties. This allowed chaos to dominate the treatment. The consultant helped the counselor slowly reframe the therapy to a more pro active rather than reactive work, which ultimately allowed for normalization of both the frequency and the length of sessions. The crises and chaos diminished.

2) Aggressive Countertransference and Iatrogenesis

I belabor the point of boundary violations and consequent iatrogenesis of alter personalities secondary to nurturing countertransference reactions in the therapist because I believe that initially these are the more compelling reactions that therapists experience and also the ones which are the most likely to run the therapy off course. However, aggressive countertransferences are not far behind. Soon depleted, the therapist falters. His countertransferences shift from a nurturing to more hostile aggressive ones because his patient is making him feel increasingly impotent, angry and helpless. We should credit Shel Silverstein (1974) for capturing that feeling very accurately in the following poem:

The Boa Constrictor

Oh, I'm being eaten
By a boa constrictor,
A boa constrictor,
A boa constrictor,
I'm being eaten by a boa constrictor,
And I don't like it one bit.
Well, what do you know?
It's nibblin' my toe.
Oh, gee,
It's up to my knee.
Oh my,
It's up to my thigh.
Oh, fiddle,
It's up to my middle.
Oh, heck,

It's up to my neck.
Oh, dread,
It's upmmmmmmmmmmmffffffff . . .

For both parties, it becomes a struggle to survive the therapy. The therapist starts feeling that the patient may not get better, or, if so, at what cost to him? The therapist may be overtly angry, provocative, and challenging to the patient. He may unnecessarily frustrate the patient by becoming more demanding and less willing to explore the usefulness/appropriateness of his interventions. By talking too much and/or too soon as well as being off track in his comments, the therapist is undermining the foundations of the treatment; he is turning the working alliance into a therapeutic misalliance.

The next section will illustrate how aggressive and angry unchecked countertransferences can in some cases foster the creation of alter personalities to deal with the perceived or real assaults within the treatment.

* Case History 4 (psychodynamic psychotherapy).

A 42-year-old female MPD patient who had been ritualistically abused spent three years in therapy with a psychodynamically oriented psychotherapist who worked, at least in theory, in a psychoanalytically oriented mode. The therapist had violated the basic ground rules of the therapy by trying to be all things to this patient, even inviting her into her home. The therapist became overwhelmed, but denied her feelings. However, she would change the patient's appointments around unpredictably, vary the length of the sessions, precipitously disinvite the patient from her home on seemingly arbitrary grounds, and refuse to take phone calls that she had initially welcomed. A protector of one of the groups of young children had considerable affection for this doctor. She created a parallel set of other young children to hate the doctor, making sure the first group of children maintained a positive image of one "nice" person in their lives.

* Case History 5 (Gestalt).

In the previously described cotherapy model (Case History 2) at one point in the treatment, the first therapist got annoyed at one of the child personalities for not yet understanding the diagnosis. The first therapist was trying to prove to a 6 year old personality that she was actually 30 years old by using a Gestalt technique that is commonly used for eating disorders, but which does not appear to work with hypnotically induced hallucinations. The first therapist challenged the child personality's self perception by forcing the patient to describe what she saw in the mirror: the child would describe long dark haired pigtails; the therapist would say "No, that's not right — Look again — you have short blond hair." This style of confrontation went on for 15 to 20 minutes, until the patient fled the session. This personality did not return to either of the therapists for three months. The patient created another child with short blond hair to "keep the peace."

3) Eroticized countertransferences and iatrogenesis.

The last group of countertransferential reactions I will

discuss are sexual/eroticized countertransferences. Langs (1974) described these as characterized by "titillating and seductive comments, seductive unnecessary deviations in technique, excessive interest in the patient's sexual behavior and fantasies, overemphasis on erotic transference and on sexual interpretations, undue focus on patients feelings towards the therapist, unconscious and conscious sanction about exploring patient's sexual acting out, utilization of erotic self revelations," and subtle forms of seductiveness (i.e., touching the patient or making direct sexual overtures). Certainly, many of the MPD patients in my case load have been sexually involved with some of their previous therapists.

* Case History 6 (reality therapy).

The patient is a 36-year-old female with MPD. Her primary psychotherapist, a female pastoral counselor, came to me for consultation. The patient was on an antidepressant and a minor tranquilizer prescribed by a psychiatrist, who had been working with her psychotherapeutically in a psychoanalytic stance. Within months of the initial consultation, the patient fled from her previous therapists and alighted on my doorstep. There had been repeated crises in her therapy, which in fact were being ignored or mishandled.

However, the other motives for her seemingly precipitous departure from her previous therapists became clear fairly rapidly. The primary therapist had been sexually involved with this patient for at least the last year of treatment. Many iatrogenic alter personalities emerged from this relationship. A personality had developed that answered to the previous therapist's name; there was a group of alters experienced as naked children in a pit, a group of angry adolescent alters who were outside the pit, and two or three gay women personalities as well. Over time, all these personalities fused into one adult gay female and one therapist personality. But, her saga was not over.

More recently she described the difficulty in "breaking up" with the psychiatrist who was prescribing medication for her in order to come to meet the psychiatrist who works with me. She discovered that in some of her alters she had also been sexually involved with the previous psychiatrist. From that exploitive relationship, she had created six personalities who were in love with him and six others who took on the characteristics of the diagnostic categories that he had considered prior to the correct diagnosis of MPD. All of these alters must be regarded as iatrogenic.

DISCUSSION

I believe that most therapists when chosing this type of career elect their field of endeavor strongly motivated to help suffering individuals. But, therapists, as any human being, will make mistakes. After all: "errare humanum est." How the errors are handled, though, will make an essential difference in the course of treatment. It is the responsibility and duty of therapists, because of the impact that they have on their patients' lives, to acknowledge and correct these errors. Working with difficult patients does not exculpate

the practitioner from this responsibility. MPD patients will test us; they will repeat with us what was done to them; they will hurt us as they were hurt; they will confuse us as they were confused. This is initially the only way they have of telling us about themselves, and we must listen. To help us listen and understand their plight more fully, we have a built in feeling mechanism — it is called countertransference (as defined in a broad sense).

Countertransferential reactions are inevitable (Langs,1974) . . .I know that when I go to work in the morning, I never leave home without them. It is not the countertransference which is problematic, but rather its use or misuse. Its misguided and unexamined mobilization can lead the therapist into a series of blunders. These errors on the part of the therapist, which range on a continuum from minor mistakes to inexcusable violations, are threatening stimuli to the patient. In the case histories which I have reviewed the therapists disrupt the treatment agreement in just those areas in which the MPD patient struggles the most: the arenas of love, anger, and sexuality. MPD patients, who as we know, typically favor dissociation as a defense respond to these errors on a continuum; they will protect themselves from us in their established ways. It may be by making a comment, but it may be by creating a new alter. The same therapist error will be responded to in different ways at different points in treatment. A patient who is learning to use other defenses in addition to or in preference to the primarily dissociative ones may not respond to a therapist's blunder by creating another alter . . . she may chose to talk about the error. However, early in treatment, when the preferred defense remains dissociation, the patient is at greater risk for the iatrogenic creation of alter personalities. Therefore framing the therapy by establishing and maintaining its limits facilitates the appropriate use of countertransference as an impetus to insight and empathy rather than as a spur to action and diminishes the likelihood of pressures toward iatrogenesis at a time when the patient is most vulnerable.

The part played by treatment modalities within the concept of iatrogenesis is fairly clear. Wolberg (1982) suggests that technical preferences by therapists are territories ruled by personal taste rather than by objective identifiable criteria and that they impinge less on the task of psychotherapy than does the consensual agreement between patient and therapist to conduct a thorough, respectful and complete therapy geared to the unification of all parts of the mind. An analogy might be drawn between this identification of a common core to crucial factors relevant to the effectiveness of therapy and Braun's observations (quoted by Kluft, 1984) that despite a number of experts' stated theoretical preferences and orientations, videotapes of their work with MPD patients indicates a considerable commonality of approach. Indeed, treatment modalities differ little in their ability to create or in their ability to protect from the creation of iatrogenic alters. The key element in decreasing the incidence of iatrogenesis is the appropriate negotiating of the countertransference, maintaining a well boundaried therapy and acknowledging and correcting mistakes rather than denying them. ■

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